state. As the primary teaching facility for the schools of medicine for Tulane University and Louisiana State University, medical students and residents had many of their clinical experiences at MCLNO. With the closure, students and residents are displaced across the state and country in other clinical sites. This may impact the future physician workforce in Louisiana, since many residents ultimately practice in the communities where they trained.

Physicians have been displaced to many communities across the nation. This has been particularly true for black physicians in New Orleans. Many black physicians practiced in the areas of the city sustaining the most severe flooding. Many offices, including significant medical equipment, were destroyed. Since many displaced physicians have established practices in their new communities, the physician shortage in Louisiana will only get worse. Ferdinand has proposed the expansion of loan repayment programs to encourage health professionals to relocate to Louisiana. This effort should also include loan repayment programs for specialty care, dental care and behavioral healthcare, and public health nurses in addition to the traditional primary care loan repayment programs. Patients living in those communities suffered substantial damage to personal property and are now displaced as well. In the recovery effort, funds have been dedicated to housing and public safety infrastructure. No dedicated funds exist for medical infrastructure, including community health centers, physician office complexes, behavioral health units and the academic medical center.

As Ferdinand points out, electronic health records (EHRs) should be included in any rebuilding effort. This EHR should establish a standard platform for interconnectivity among community health centers, private offices, hospitals, behavioral health centers, social service agencies, pharmacies and health plans. This shared platform will result in comprehensive healthcare, reduced duplication of tests and services as well as improved patient safety across the continuum of healthcare. This medical infrastructure rebuilding effort should serve as a platform for community-based healthcare through private practices as well as community health centers with the integration of the EHR. A key feature of the EHR will be the availability of information and records in multiple remote locations should a disaster strike again, if a web-based solution is developed. This format can be used for any community or state for integration of health services through an EHR.

I would summarize these hurricane Katrina healthcare recommendations as we move forward to rebuild healthcare adapted from the Institute of Medicine's report, "Insuring America: Principles and Recommendations."

1. Develop a safe, efficient, equitable and effective patient-centered system of primary care centers, multispecialty groups, private physicians and the academic health center that focuses on ambulatory care, chronic care management, health promotion and disease prevention.
2. Develop an academic health center to serve all professional health schools, including medical, dental, nursing, pharmacy, public health and podiatry.
3. Focus on the 10 essential public health services.[3]
4. Develop and integrated EHR utilized by all consumers, providers and payers of health services.
5. Prepare the healthcare infrastructure for future disasters.

Hurricane Katrina has exposed the weaknesses of the current fragmented system of healthcare that exists in all areas of the country, particularly those areas with large numbers of uninsured and medically disadvantaged patients. This is true for most urban communities, except those with a large coverage by health plans, such as the Kaiser-Permanente system. Any large-scale natural disaster, including flooding, earthquakes and hurricanes, may result in a major disruption of healthcare. As we rebuild New Orleans and the Gulf Coast region, our lessons learned can serve to strengthen healthcare throughout the nation.

REFERENCES

1. Ferdinand KC. Public Health and Hurricane Katrina: Lessons Learned and What Can We Do Now. *J Natl Med Assoc.* 2006;98:271-274.

2. Institute of Medicine. Insuring America's Health: Principles and Recommendations. National Academies Press, 2004.

3. Reedy AM, Luna RG, Olivas GS, et al. Local public health performance measurement: implementation strategies and lessons learned from aligning evaluation indicators with the 10 essential public health services.

Myra A. Kleinpeter, MD, MPH
Associate Professor of Medicine
Tulane University
Health Sciences Center
1430 Tulane Ave., SL–45
New Orleans, LA 70112
phone: (504) 988-5346
fax: (504) 988-1909 or
(504) 988-1600
mkleinp@tulane.edu

Authors' response: Continuing Hurricane Katrina Public Health Crisis

It is always the hallmark of good medical and public health policy that clinicians and researchers continue to expand and refine our approaches to pressing health issues. The remarks of the letter above are well thought-out and add to this discussion of our response to the largest natural disaster ever to

impact the United States. Furthermore, two additional areas that need to be addressed are the continuing strain on the operations of the few full-service inpatient facilities in New Orleans post-Katrina because of the uncompensated care (and rightfully so) and the need to license volunteer physicians in an expedited manner by the Louisiana State Board of Medical Examiners (LSBME). Recently, the first problem has been addressed with $383 million in federal funds for Louisiana hospitals, doctors and others to provide for the uninsured. As a member the of the LSBME, I strongly urge all physicians sign up for the Federation Credentials Verification Service to create and maintain a permanent file of core credentials. This will expedite doctors who desire to come to the state to volunteer services (licensure still required) or for displaced clinicians who often desperately seek an income in other states with their practices and personal lives shattered. The Federation of State Medical Boards has further information at www.fsmb.org.

Keith Ferdinand, MD
Association of Black Cardiologists
5355 Hunter Road
Atlanta, GA 20239
phone: (404) 201-6632
kcferdmd@aol.com

Master African-American Artists Should be Featured on *JNMA* Covers

Dear Ms. Taylor,

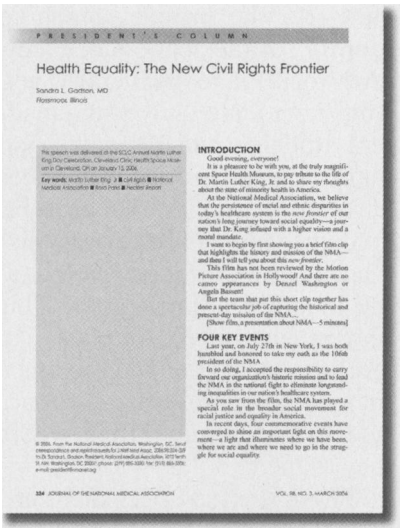
As a major collector of art by African Americans, I was truly disappointed in your selection of cover art by putting someone on the cover who is not a major artist. Then to have essentially an advertisement for the gallery is worse. In the Washington, D.C. area, you have major African-American collections at Howard University. The Thurlow E. Tibbs collection at the Corcoran gallery, the David Driskell collection, and Hampton University—to name a few. I am responsible for the art by African Americans being featured on the front cover of the *Journal of American Medical Association*.

This journal presents an outstanding canvas by an outstanding artist, with an insightful write-up on the artist and painting. There are major authorities in your area who could help you improve your selection for your up-coming covers. If you are going to do this, please do it with class, that has been long overdue to the great African-American Masters. Looking forward to hearing from you.

Respectfully,
Harmon W. Kelley, MD, FACOG
Southeast OB/Gyn Associates
4115 E. Southcross Blvd.
Suite 102
San Antonio, TX 78222
amhernandez@wireweb.net

Socioeconomic Inequities Often Translate into Health Inequalities

It is with great interest that we read Dr. Gadson's speech for the SCLC Annual Martin Luther King Day Celebration: "Health Equality: The New Civil Rights Frontier."[1] We wholeheartedly agree with her conclusions related to inequality in healthcare across the racial and socioeconomic divide. We find the same issues relating to levels of care for drug addiction. Opioid abuse and dependence are significant public health problems affecting people of all racial and socioeconomic backgrounds. Interestingly, physicians, especially anesthesiologists and surgeons, are overrepresented among opioid


PRESIDENT'S COLUMN

Health Equality: The New Civil Rights Frontier

Sandra L. Gadson, MD
Rossmoor, Illinois

INTRODUCTION

FOUR KEY EVENTS

abusers.[2] For over 30 years, methadone has been the treatment of choice for addiction to opioids and intravenous opiate abusers. Strict supervision in a specialized drug treatment program has been the standard for methadone maintenance treatment.[3] But what about physician addicts—do they receive the same advice and treatment? Can we discern what physicians think is the treatment of choice by looking at recommendations given to their colleagues?

We studied State of Florida physicians referred to the Board of Medicine and Professionals Resource Network for opioid abuse and dependence. Treatment referrals were made to various addiction treatment facilities throughout the United States, and outcomes were collected. A specific treatment contract was negotiated with each physician and filed. Outcomes were assessed by written counselor reports, physician/psychiatrist evaluations, AA/NA attendance, return to work and the quantitative result of regular, random urine testing.[4]

None of the physicians were referred for or treated with methadone maintenance therapy. All were referred for detoxification and long-term drug-free